IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, et al.,
Defendants-Appellants.

vs.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, et al.,
Plaintiffs-Appellees.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

AMICUS CURIAE BRIEF OF THE BLUE SHIELD ASSOCIATION

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases:

Statutes and Regulations:

Congressional Hearings:

Other Authorities:

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Blue Shield Association ("BSA"), a nonprofit association of seventy nonprofit medical prepayment plans located throughout the United States, submits this brief as *amicus curiae* in support of the defendants-appellants' request to reverse the judgment of the United States Court of Appeals for the Fifth Circuit and affirm the judgment of the United States District Court for the Western District of Texas in this case. This brief is filed with the consent of all the parties. (See Appendix A.)

THE INTEREST OF THE *AMICUS CURIAE*

More than 85 million persons in the United States were served by sixty-nine Blue Shield Plans* in both private and government business during 1976. In 1976 alone, Blue Shield Plans paid out more than $8 billion in medical benefits for their subscribers. Blue Shield Plans are nonprofit and belong to the Blue Shield Association, a nonprofit organization which, among other things, administers the various Membership Standards relating to containment of health care costs.

More than seven million subscribers of Blue Shield and Blue Cross Plans nationwide have coverage under out-of-hospital prescription drug insurance programs which contain provisions similar to those challenged in this case. The Plans processed more than thirty million claims and paid out over $165 million in benefits under these programs during 1976. A substantial proportion of the claims and benefits were covered pursuant to a collective bargaining agreement between the United Automobile Workers and the domestic automobile manufacturers; forty-two Plans processed claims under the automobile industry program.

The drug program operates in a manner which permits market forces in the retail drug industry to determine the price of a retail prescription while enabling the Plan to predict and control the total cost of the program to the subscribers as a whole. The Fifth Circuit's repeated characterizations of the program as "price-fixing" reveal a misunderstanding of the

* Appendix B to the attached brief lists the seventy Blue Shield Plans in the United States. One Plan was added in 1978.

program's operation. It is therefore essential to explain at the outset how the program works and how it was developed.

Pharmacies which wish to participate in the program sign a "participating pharmacy agreement." A participating pharmacy is reimbursed by the Plan in an amount equal to the acquisition cost of the drug, *plus* a dispensing fee, *minus* the amount of any deductible. The participating pharmacy, in turn, agrees not to charge subscribers more than the deductible, if any. Pharmacies are free to charge subscribers the full amount of the deductible (for example, $2.00) or only a portion of the deductible (for example, $1.00), or nothing at all.

It may be useful to consider each of these three components separately. The first component, the acquisition cost, is merely the price paid by the pharmacist for the drug and is not affected by the Plan or the participating pharmacy agreements. *Cf.* U.S. Dep't of Health, Education, & Welfare, Task Force on Prescription Drugs, *Background Papers: Approaches to Drug Design* 18 (1969) (acquisition cost basis for reimbursement does not interfere with present marketing and pricing systems) (hereinafter "HEW Task Force"). Most agreements do, however, permit the Plan to monitor these charges to be sure that it is being charged the amount the pharmacist actually paid for the drug. (See Prototype Agreement, Appendix C.)

The second component, the dispensing fee, is merely a unilateral offer from the Plan to each pharmacy to provide services for a specified price. On the assumption that some pharmacies may elect not to discount the deductible at all, the Plan calculates the dispensing fee so as to make it advantageous for most pharmacists to participate in the program. An individual pharmacy,

like any seller, will accept the Plan's offer to participate only if it considers the offer to be economically desirable. Plans periodically adjust the dispensing fee to continue to attract a sufficient number of participating pharmacies.

The third component, the deductible, is determined by the insurer and the insured and depends, in part, on the total amount the customer is willing to pay for the insurance. *Problems on Third Party Prepaid Prescription Programs: Hearings Before the Subcomm. on Environmental Problems Affecting Small Business of the House Permanent Select Comm. on Small Business*, 93d Cong., 1st Sess., 102-03, 205 (1973) (hereinafter "1973 Hearings") (testimony of Donald G. Puscas).* The extent to which the deductible is discounted by the pharmacy is determined in the marketplace. By discounting the deductible, pharmacists can and do compete for the business of Plan subscribers just as they compete for the overwhelming proportion of prescriptions which are not covered by insurance.**

There is thus no "retail price" for prescription drugs dispensed by participating pharmacies under this

* The amount the customer is willing to pay for the program is itself, of course, determined in a competitive market. Efficient insurers who have lower overhead costs and are able to offer more benefits for the same rate (or the same benefits at a lower rate) will get more business.

** Goldberg & Loren, *The UAW Negotiated Prepaid Prescription Drug Program*, NS12 J. Am. Pharm. A. 422, 425 (1972) ($2.00 copayment discounted to 89 cents in some areas) (hereinafter "Goldberg & Loren"). For example, a discount of $0.50 from the most common deductible of $2.00 can save a Plan subscriber 25 percent of his out-of-pocket cost, which also constitutes almost 10 percent of the $5.66 average cost of prescriptions filled at retail pharmacies in 1976. Eli Lilly & Co., *Lilly Digest: A Survey of Community Pharmacy Operations for 1976* 26 (1977) (average cost of prescriptions).

program. Rather, a Plan's subscribers are entitled to receive covered prescription drugs in return for paying a premium, subject only to the payment of a deductible which may be discounted.

Alternatively, a subscriber may elect to purchase drugs from a "nonparticipating pharmacy," in which event the subscriber pays the pharmacy the full prescription price and files his own claim with the Plan. He is reimbursed for a specified percentage (commonly 75 percent) of the pharmacy's "usual and ordinary" charge in excess of the applicable deductible. (See Prototype Agreement, Appendix C.) The out-of-pocket cost is usually less for a subscriber who has a prescription filled at a participating pharmacy. The Plans' prescription drug reimbursement mechanism therefore provides an incentive for each subscriber to patronize participating pharmacies. The reason for this is simple—the Plans' costs of reimbursing participating pharmacies are generally lower than direct reimbursement of each subscriber, so this incentive is designed to help keep premium rates down.

The challenged reimbursement mechanism is universally regarded as a sound cost containment device. Indeed, the Department of Health Education and Welfare has specifically approved this reimbursement formula for drugs used in federal programs it funds and administers. Almost every state government uses the acquisition cost plus dispensing fee formula to reimburse pharmacists who provide drugs under Medicaid. The same formula is employed by the Department of Defense in its CHAMPUS (Civilian Health and Medical Program for the Uniformed Services) program, and the formula also appears in programs offered by commer-

cial insurers and those required by numerous collective bargaining agreements.

Blue Shield and Blue Cross Plans' prescription drug programs were first implemented in the late 1960's as a result of the collective bargaining agreement between the United Automobile Workers and the domestic automobile manufacturers. Because no one had previously attempted to calculate a dispensing fee, the Michigan Plan undertook an extensive study of current prices and published data pertaining to pharmacies' operations and costs in Michigan. As a result of this study, the Plan determined to offer an initial dispensing fee approximately 10 percent higher than the "average" dispensing fee, calculated using empirical data reflecting the costs of providing the customary level of services for most pharmacies (such as record-keeping, delivery, and emergency and consulting services).

Of necessity, the Michigan Plan and other Blue Shield and Blue Cross Plans calculate their dispensing fees so as to satisfy the varying needs of many different types of pharmacies. Blue Shield and Blue Cross Plans' prescription drug programs account for less than 2 percent of all retail drug sales in the United States. If the Plans' dispensing fees were unrealistically low, pharmacies could elect not to participate.

Finally, it should be emphasized that Blue Shield and Blue Cross Plans are nonprofit organizations dedicated to serving the public. The pharmacy agreements challenged in this lawsuit were designed specifically to contain costs, insofar as feasible, for the ultimate benefit of patients and subscribers. Any increase in costs which might result from the decision below would, ultimately, be borne by the consuming public generally.

SUMMARY OF ARGUMENT

The Fifth Circuit's restrictive concept of the "business of insurance" includes relationships between the insurer and the insured, while excluding agreements between the insurer and the provider of services. The court below presumes that the efforts of the states and insurers to control costs (by regulating insurer-provider agreements) have no place in the "business of insurance." In stark contrast, however, state and federal regulatory and judicial authorities unanimously agree that cost containment is an essential activity, if not a fundamental responsibility, of the "business of insurance."

Moreover, numerous state and federal officials have recognized that agreements between insurers and providers, and in particular the pharmacy agreements in this case, effectively control the costs upon which premium rates are based. Therefore, the pharmacy agreements unquestionably constitute the "business of insurance."

The Fifth Circuit's decision, which does not consider these fundamental characteristics of health insurance, would create almost insurmountable obstacles to effective state regulation. By subjecting the insurer-provider relationship to the federal antitrust laws, while leaving the integrally related insurer-insured relationship to the demands of state regulatory policies, the decision below would interfere with state regulation of both relationships and place the insurer in the untenable position of attempting to comply with potentially conflicting policies.

The Fifth Circuit apparently failed to appreciate the consequences of its piecemeal application of the McCarran-Ferguson Act, perhaps as a result of a misunderstanding of the operation of the prepaid drug program in general and of the pharmacy agreements in particular. The characterization of the pharmacy agreements as "price-fixing", 556 F.2d at 1381, conflicts with the assessments of various Department of Justice officials who followed the development of prepaid drug programs and who specifically reviewed similar agreements pursuant to the Department's Business Review Procedure.

ARGUMENT

I.

THE "BUSINESS OF INSURANCE" INCLUDES COST CONTAINMENT EFFORTS.

The Fifth Circuit's narrow focus on the relationship between the insurer and the insured failed to take account of the realities of efficiently providing health insurance benefits to millions of Americans in today's marketplace. In particular, the Fifth Circuit failed to recognize that there are at least three parties—not two—who play crucial roles in the health insurance industry: the insurer, the insured, and the provider of health care services. The Fifth Circuit excluded from the "business of insurance" insurer-provider agreements used to control and predict costs. Thus, the Fifth Circuit reached the startling conclusion that cost containment has no place in the "business of insurance" at a time when state and federal authorities across the country are concentrating their efforts on controlling the costs of health insurance. 556 F.2d at 1382.

Unlike the many responsible authorities who urge the Plans to control costs, the Fifth Circuit said that a Plan's obligation as an insurer is solely to pay health care providers *whatever* they charge:

> Just as the automobile insurer is obligated to pay the cost of repair, *whatever it might be*, over and above the applicable policy deductible, Blue Shield is obligated to pay the cost of prescription drugs. . . .

556 F.2d at 1381.* If health care costs were to increase radically as a result of the imposition of a passive reim-

* Unless otherwise indicated, all emphasis in this brief has been added.

bursement policy, state insurance commissioners and health insurers should, according to the Fifth Circuit's directive, merely "establish and periodically adjust . . . [the] rate structure to reflect the impact of inflation." 556 F.2d at 1382. The rejection of cost containment as a legitimate and indeed necessary aspect of the "business of insurance" would disregard the purpose of the McCarran-Ferguson Act and propel the federal courts headlong into the business of insurance rate regulation, the very core of the state-regulated insurance business.

The following discussion will demonstrate that the Fifth Circuit's analysis of the "business of insurance" is fatally deficient in several respects. First, mechanisms designed to minimize health insurance premiums by containing costs are a fundamental aspect of the "business of insurance." Second, agreements between insurers and providers of health care services, such as pharmacy agreements, are a widely recognized, effective mechanism for controlling health care costs. Third, agreements between an insurer and a provider of health care services, which enable insurers to charge lower rates based on reliable cost predictions, unquestionably constitute the "business of insurance." Fourth, application of the federal antitrust laws to insurer-provider agreements would impair state regulation of the insurance business and insurers' compliance with state regulatory requirements.

A. Mechanisms Designed To Minimize Costs Are An Essential Aspect Of The "Business Of Insurance."

Contrary to the Fifth Circuit's view, Blue Shield Plans, state regulatory authorities and, indeed, the federal courts, see cost containment as a fundamental aspect, if not a primary responsibility, of the "business

of insurance." Joseph A. Califano, Jr., Secretary of the United States Department of Health, Education, and Welfare, and William Lilly III, former acting director of the President's Council on Wage and Price Stability, have contended that one reason costs have risen so drastically is that health care providers are allegedly unresponsive to market demands. *See Curbing the Cost of Health Care*, Bus. Week 82 (April 4, 1977). Representatives of all segments of society are calling on third party payors such as Blue Shield Plans *to control these costs* through provider reimbursement mechanisms. *See, e.g.*, Herzlinger, *Can We Control Health Care Costs?*, 56 Harv. Bus. Rev. 102, 108-09 (1978) (Assoc. Prof. Bus. Adm., Harvard Bus. School); Council on Wage & Price Stability, *Employee Health Care Benefits: Labor-Management Innovations in Controlling Costs*, 41 Fed. Reg. 40298 *et seq.* (1976); Bailey, *Rising Health Care Costs—a Challenge to Insurers*, Nat'l J. 608 (May 1, 1976) (President, Aetna Life & Cas.); Zink, *Greater Effort Needed to Control Costs*, 50 Hosp. 65 (March 16, 1976) (Director, Employee Benefits and Services, General Motors Corp.); *Commercial Health and Accident Insurance Industry: Hearings Before the Subcomm. on Antitrust and Monopoly of the Senate Comm. on the Judiciary*, 92d Cong., 2d Sess., Part 1, 387 *et seq.*, (1972) (statement of Herbert S. Denenberg, Insurance Comm'r for State of Pennsylvania).

Blue Shield Plans have long regarded cost containment as a primary responsibility of their business. Accordingly, the Plans have adopted a variety of cost containment programs which have resulted in savings of millions of dollars for their subscribers. In 1977 alone their utilization and peer review of claims submitted by

providers resulted in a savings of more than $22.9 million. Their usual, customary and reasonable ("UCR") reimbursement mechanism to providers resulted in a reduction of more than $370.9 million in providers' charges to the Plans. Other programs such as coordination of benefits resulted in a saving of more than $45.0 million to their subscribers. A Director of Insurance Economics at the Chase Econometrics Insurance Forecasting Service recently reported that an industry-wide adoption of the Blue Shield guidelines on obsolete medical procedures could result in a total savings of $78.0 million to United States insurance companies. *See Ins. Advocate* 14 (July 23, 1977). One of the Membership Standards administered by BSA specifically requires Blue Shield Plans to develop effective cost containment programs and BSA is actively monitoring the Plans' compliance with that standard.

State statutes regulating the Plans give the state insurance commissioners extensive authority over cost containment efforts through their regulation of premium rates, benefits, and provider reimbursement levels. These statutes often require the insurance commissioners to fix or approve the premium rates charged and the contracts issued to the Plans' subscribers. *See, e.g.*, Conn. Gen. Stat. 1975, § 33-172; Kan. Stat. Ann. § 40-1906 (1973); N.M. Stat. Ann. § 58-25-16, § 58-25-17 (Supp. 1975). In addition, many state statutes contemplate that the Plans will enter into agreements with providers or groups of providers who agree in advance to render services to the Plans' subscribers for a certain amount or reimbursement method approved by the state insurance commissioners. *See, e.g.*, 40 Pa. S. § 1558 (Supp. 1977); Fla. Stat. Ann. § 641.03 (1972); Mass. Ann. Laws ch. 176B, § 4 (1977). Frequently, other aspects of

the Plans' contracts with providers must conform to various state statutory requirements. *See, e.g.*, Md. Code Ann. Art. 48A, § 355(b)(2) (Supp. 1977); Calif. Health & Safety Code § 1367(h) (West Supp. 1978). Beyond the authority over rates charged and contracts issued to providers and subscribers, the state insurance commissioners often have substantial power to conduct sweeping investigations of Plans and to alter almost *any* aspect of the Plans' operations. *See, e.g.*, Ill. Rev. Stat. 1975, ch. 32, § 557; N.Y. Ins. Law § 251 (McKinney 1966); Utah Code Ann. § 31-37-21 *et seq.* (Supp. 1973).*

Armed with the foregoing extensive regulatory authority, state insurance commissioners throughout the country have regarded cost containment as one of their primary responsibilities in regulating the business of health insurance. For example, former Pennsylvania Insurance Commissioner Herbert S. Denenberg told the Senate Subcommittee on Antitrust and Monopoly a few years ago:

> Since January 1971, we have been able to clearly identify the contribution of Blue Cross and Blue Shield to cost and quality control. . . .
>
> These controls call for the elimination of unsafe and unnecessary facilities; the use of generic drugs rather than their more expensive brand name equivalents; limitations on payments for interns and residents; more precise accounting methods; protection of patients from being charged for services deemed medically necessary [*sic*]; hospital safety programs to protect patients from needless injuries; and many other reforms. . . .

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* For a general discussion of the states' regulation of Blue Shield Plans, see the statement of the former Executive Director of the National Association of Insurance Commissioners, *National Health Insurance Proposals: Hearings before the House Comm. on Ways and Means*, 92d Cong., 1st Sess., Part 2, 406-07, 429 (1971).

. . .

> Other experiments in cost control through reimbursement are being carried out by other Blue Cross plans across the United States.
>
> We have asked the commercial insurance companies to document their cost and quality control measures.

Commercial Health and Accident Insurance Industry: Hearings Before the Subcomm. on Antitrust and Monopoly of the Senate Comm. on the Judiciary, 92d Cong., 2d Sess., Part 1, 388-389 (1972).

Other state insurance commissioners' vigorous regulation of health insurers' cost containment efforts indicate that they too regard cost containment as an essential activity of the "business of insurance". For example, in 1974 Vermont's Insurance Commissioner held hearings into the efforts of his state's Blue Cross Plan to "help keep down hospital costs" and ordered the Plan to improve its procedures for reviewing whether or not persons should be hospitalized. *Ins. Digest* (Aug. 24, 1974). The Florida State Insurance Commissioner recently called upon the Florida Plans to work even more diligently in the area of cost containment. Florida, Office of the Treas., Ins. Comm'r, *Order re Approval of Increase in Rates* 7, Case No. 77-Rate-09H (filed Nov. 23, 1977). Insurance commissioners in Illinois, New York and Michigan have also issued various directives ordering the Plans to implement certain cost containment programs. Illinois, Dep't of Ins., *Order re Proposed Rate Revisions*, Hearing No. 1607 (filed April 8, 1978); New York, Sup't of Ins., *Opinion & Decision re Blue Cross of Northeastern N.Y., Inc.* (effective Jan. 1, 1977); Michigan, Dep't of Commerce, Ins. Bureau, *Order Transmitting Proposed Rules*, No. 77-R-101 (July 25, 1977).

In addition to the Plans and the state insurance commissioners, federal courts have recognized that the efforts of Blue Shield or Blue Cross Plans to minimize premium rates by containing costs constitute the "business of insurance" within the McCarran-Ferguson Act. For example, in *Doctors, Inc. v. Blue Cross of Greater Phila.*, 431 F. Supp. 5 (E.D. Pa. 1975), *aff'd*, 557 F.2d 1001 (3d Cir. 1976), the district court noted that the state's insurance department had urged the Plan to "exert pressure on the . . . hospitals to limit or do away with unnecessary services in order that insurance rates in Pennsylvania could be lowered." 431 F. Supp. at 10. The Plan, in turn, refused to pay for unnecessary services and to reimburse directly hospitals which performed such services. 431 F. Supp. at 6, 7. When a hospital disgruntled with the Plan's efforts to discourage unnecessary services charged an unlawful conspiracy between the Plan and other hospitals to eliminate competition, the court rebuffed the hospital's efforts to interfere with the cost control program and recognized the state's interest in minimizing insurance rates by lowering health care costs: "[T]he only way to lower insurance rates in Pennsylvania or anywhere would be to lower costs of health care. Therefore, it is clearly within the business of insurance to try to get the health care providers to cut costs." 431 F. Supp. at 10.

Similarly, in *Frankford Hosp. v. Blue Cross of Greater Phila.*, 417 F. Supp. 1104 (E.D. Pa. 1976), *aff'd*, 554 F.2d 1253 (3d Cir.), *cert. denied*, ... U.S. ..... (Oct. 3, 1977), the state authorities insisted that the Plans' contracts with hospitals include quality controls and ceilings on total cost reimbursement. 417 F. Supp. at 1107. A hospital dissatisfied with the cost control terms of the proposed contract with the Plan filed a class action antitrust suit on behalf of all contracting hospitals alleging, among other things, that the Plan had "coerced" the hospitals into signing the agreements in furtherance of

its plan to monopolize the health insurance market. *Id.* at 1108. Rejecting the plaintiff's allegations, the court specifically recognized the state's and the Plan's legitimate interest in minimizing rates by controlling health care costs as a part of the "business of insurance." *Id.* at 1106-09. *See also Travelers Ins. Co. v. Blue Cross of Western Pa.*, 481 F.2d 80, 83 n.9 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973); *St. Bernard Gen. Hosp. v. Hospital Serv. Ass'n of New Orleans, Inc.*, 1978-1 Trade Cas. (CCH) ¶ 61,868 (E.D.La. 1977); *Western Health Care Corp. v. Colorado Hosp. Serv.*, C.A. No. 76-M-760 (D. Colo. Feb. 16, 1977); *Nankin Hosp. v. Michigan Hosp. Serv.*, 361 F.Supp. 1199, 1203 (E.D. Mich. 1973) (certain Plan procedures and standards adopted "for the protection of its subscribers" because of the state's "concern over rising costs of hospital care").

In sum, in sharp contrast to the Fifth Circuit's delineation of the "business of insurance," Blue Shield Plans, state insurance commissioners, and federal courts have regarded cost containment as an essential aspect of the "business of insurance" within the meaning of the McCarran-Ferguson Act. Furthermore, as the next section will document, agreements between the insurer and the provider of services to the insured have been widely recognized by state and federal authorities as effective methods of controlling costs.

B. Agreements Between Insurers And Providers Of Services Are Widely Recognized As An Effective Method Of Controlling Costs.

Agreements between Blue Shield Plans and providers such as participating pharmacies constitute a widely recognized and effective method of minimizing health insurance premiums by controlling the administrative costs and the costs of claims. A review of the cost-saving

elements of the pharmacy agreements is presented below.

Administrative costs are lower when the pharmacy, rather than the subscriber, files the claim, because the claims are more accurate, there are fewer parties involved, and the claims are more easily processed on electronic data processing equipment. *HEW Task Force* at 14. *See also* U.S. Dep't of Health, Education, & Welfare, Health Care Financing Admin., *Research in Health Care Financing* 38 (Spring/Summer, 1977) (results of HEW sponsored pilot study show "significantly" higher administrative costs with patient billing). Claims costs are lower because the participating pharmacy has agreed in advance to accept the acquisition cost plus dispensing fee (less deductible) as full reimbursement from the Plan, which prevents the pharmacy from charging any amount, whatever it may be, to the Plan and to the subscribers.

Furthermore, both administrative and claims costs are reduced by the acquisition cost plus dispensing fee formula because Plans can monitor charges effectively at reasonable administrative cost. With respect to the acquisition cost component, the Plan can compare the amount it is charged for the drug with the pharmacist's cost of acquiring it. With respect to the dispensing fee, the Plan can monitor the amount it pays for the pharmacist's services, including overhead and profit, in an effort to avoid exceeding their average market value without having to compare each claim with each pharmacy's usual charge for the same service. *Third Party Prepaid Prescription Drug Programs: Hearings before the Subcomm. on Environmental Problems Affecting Small Business of the House Select Comm. on Small Business*, 92d Cong., 1st Sess., 292 (1971) (hereinafter "1971 Hearings") (testimony of Waldo A. Stevens).

Federal agencies have explicitly and implicitly recognized the cost effectiveness of the reimbursement formula implemented by the participating pharmacy agreement. A study released by the Council on Wage and Price Stability reported that "contractual agreements with thousands of retail pharmacies to pay the wholesale price for prescription drugs, plus a fixed 'professional fee' for the dispensing service" achieved savings averaging an estimated 15 percent to 20 percent of the retail market price charged to uninsured customers or by nonparticipating pharmacies. Council on Wage & Price Stability, *The Complex Puzzle of Rising Health Care Costs: Can the Private Sector Fit It Together?* 119 (Dec. 1976).

A Task Force of the Department of Health, Education and Welfare also concluded that the acquisition cost plus dispensing fee formula results in reduced drug expenses for those who frequently purchase high-priced prescriptions, lends itself to automatic claims processing and low administrative costs, and tends to result in lower program costs. *HEW Task Force* at 27. Based on the Task Force Study, an HEW Review Committee recommended that this reimbursement formula be embodied in provider contracts for drug benefits under Medicare. U.S. Dep't of Health, Education, & Welfare, Office of the Secretary, *Report of the Secretary's Review Committee of the Task Force on Prescription Drugs* 7-8 (1969).

Indeed, HEW thought so highly of the reimbursement formula that it specifically approved the formula "for reimbursement or payment purposes for any drug used in the programs or activities" which it funds or administers. U.S. Dep't of Health, Education, & Welfare, *Regulations*, 45 C.F.R. § 19.3(a)(2) (1976). Consequently,

almost every state uses this formula to reimburse pharmacists who provide drugs under Medicaid. *Medicaid Fee Freeze Affects Nearly Half the States*, Drug Topics 13 (Aug. 1, 1977). Many states use provider contracts identical in relevant respects to those utilized by the Plans to implement their Medicaid programs. *See, e.g.*, U.S. Dep't of Health, Education, & Welfare, Task Force on Prescription Drugs, *Background Papers: Current American & Foreign Programs* Appendix G (Dec. 1968) (Kentucky agreement). Acquisition cost plus dispensing fee reimbursement is also utilized in the CHAMPUS (Civilian Health and Medical Program for the Uniformed Services) program underwritten by the federal government, in programs offered by other commercial insurers, and in programs required by collective bargaining agreements. Health Ins. Ass'n of Am., *Health Insurance and Prescription Drugs: A Study by D. Jones & J. Follmann, Jr.*, 50 (commercial insurers), 70 (unions), 82 (CHAMPUS) (1971); Pharmaceutical Mfrs. Ass'n, *Pharmaceutical Payment Programs—An Overview: The Financing of Prescription Medicines Through Third Party Programs* 24 (1973).

Besides the federal authorities, state insurance commissioners recognize the cost effectiveness of provider agreements by constantly exercising their statutory authority over the terms of such agreements. For example, former Pennsylvania Insurance Commissioner Herbert Denenberg told a Senate Subcommittee:

> We have been able to generate new cost and quality controls by insisting on incorporation of long overdue reforms in the contracts which Blue Cross plans enter into with member hospitals.
>
> These contracts control over one-half billion dollars in yearly payments to hospitals for services

rendered to subscribers of Pennsylvania Blue Cross plans.

. . .

Blue Cross in Pennsylvania is not satisfied with the traditional cost and quality controls of their hospital contracts. They are experimenting with new cost control reimbursement arrangements.

Commercial Health and Accident Insurance Industry: Hearings before the Subcomm. on Antitrust and Monopoly of the Senate Comm. on the Judiciary, 92d Cong., 2d Sess., Part 1, 388-389 (1972). State insurance commissioners in Illinois and Michigan also have ordered Plans to develop additional cost containment programs by adding certain specified provisions to their contracts with providers of health care services. Illinois, Dep't of Ins., *Order re Proposed Rate Revisions*, Hearing No. 1607 (filed April 8, 1978); Michigan, Dep't of Commerce, Ins. Bureau, *Order Transmitting Proposed Rules*, No. 77-R-101 (July 25, 1977).

Efforts of other state insurance commissioners to control health care costs by regulating the Plans' agreements with providers of health care services are fully documented in several opinions holding that provider agreements constitute the "business of insurance." *See Frankford Hosp. v. Blue Cross of Greater Pa.*, 554 F.2d 1253 (3d Cir.), *cert. denied*, ... U.S. ..... (Oct. 3, 1977); *Travelers Ins. Co. v. Blue Cross of Western Pa.*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973); *St. Bernard Gen. Hosp. v. Hospital Serv. Ass'n of New Orleans, Inc.*, 1978-1 Trade Cas. (CCH) ¶61,868 (E.D. La. 1977); *Western Health Care Corp. v. Colorado Hosp. Serv.*, C.A. No. 76-M-760 (D. Colo. Feb. 16, 1977); *Anderson v. Medical Serv. of D.C.*, 1976-1 Trade Cas. (CCH) ¶60,884 (E.D. Va. 1976), *aff'd*, 551 F.2d 304 (4th Cir. 1977).

C. Agreements Between An Insurer And The Provider Of Health Care Services Constitute The "Business Of Insurance."

This Court has recognized that the "business of insurance" is not confined to the insurer-insured relationship. *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969). The Fifth Circuit agreed with this Court's previous observation that the "business of insurance" includes "other activities which relate . . . to [the insurers'] status as reliable insurers." 556 F.2d at 1380. The Fifth Circuit failed to understand, however, that the pharmacy agreements vitally affect both the insured and the reliability of the insurer, not only because they minimize premium rates by controlling costs, but also because they enable the insured and insurer to predict accurately the costs of benefits to be provided under the program. Thus, they unquestionably constitute the "business of insurance" within the meaning of the McCarran-Ferguson Act.

The cost plus dispensing fee reimbursement formula is the *only* practicable means of predicting the cost of a program of providing benefits for eight million claims for reimbursement for prescription drugs purchased by several million subscribers from thousands of pharmacies, and of offering the program at reasonable cost. *1971 Hearings* at 290-292 (testimony of Waldo A. Stevens). Thus, the pharmacy agreements were used by the Michigan Plan to implement the drug program negotiated by the UAW and automobile companies in order to satisfy the demands of both the companies and the union for a program which would provide meaningful benefits at a reasonable cost. Goldberg & Loren at 423-24. As a Blue Cross official told the House Subcommittee, predictability was also important:

> Well, our customer, in this case many of the industries, would have to know the cost of providing

> this benefit to its employees would be reasonable, that you could reasonably predict the cost of this benefit to their employees. In other words, General Motors or the Ford Motor Co. would not like it if we set up a drug program that they negotiated and purchased and if after a year we had to increase the premium rates 50 percent. What they like is reasonable predictability of cost built within the program, and unions especially are after that control and predictability feature.

1971 Hearings at 291 (testimony of Waldo A. Stevens).

If the Plans could not deliver promised drug benefits at the rate charged, customers would view them as unreliable. The increased costs of programs without effective cost controls is one of the major reasons employers cancel health insurance contracts. Rose, *Meeting the Challenge of Rising Hospital Costs*, J. of Health Politics, Policy & L. 146 (Summer 1976). The Fifth Circuit could not have considered the effect of unpredictable and uncontrolled costs on the relationship between the insurer and the insured when it suggested that the way to avoid the impact of its decision on rates would be for the Plan simply to raise them. 556 F.2d at 1382.

Contrary to the Fifth Circuit's suggestion in its attempt to distinguish the *Travelers* case, 556 F.2d at 1382, the fact that the specific terms of a particular pharmacy agreement are not expressly *mandated* by the state insurance commissioner does not remove the agreement from the "business of insurance." A similar argument advanced by the Federal Trade Commission was rejected by this Court in *FTC v. National Cas. Co.*, 357 U.S. 560 (1958):

> Each State in question has enacted prohibitory legislation. . . . Petitioner does not argue that the statutory provisions here under review were mere pretense. Rather, it urges that a general prohibition . . . is too 'inchoate' to be 'regulation' until that prohibition has been crystallized into 'administrative elaboration of these standards and application in individual cases.' However, assuming there is some difference in the McCarran-Ferguson Act between 'legislation' and 'regulation,' nothing in the language of that Act or its legislative history supports the distinctions drawn by petitioner. So far as we can determine from the records and arguments in these cases, the proviso in Section 2(b) has been satisfied.

357 U.S. at 564. Thus, regulation which generally prohibits, proscribes or permits conduct is sufficient under the McCarran-Ferguson Act.

The lower courts have uniformly followed this principle. For example, in *Ohio AFL-CIO v. Insurance Rating Bd.*, 451 F.2d 1178 (6th Cir. 1971), *cert. denied*, 409 U.S. 917 (1972), the court noted that although a number of cases considered arguments that the exemption was unavailable because of a lack of regulation, ". . . in no case has it been decided that the exemption was inapplicable because of a failure of state regulation." 451 F.2d at 1183. The court held that:

> [T]here is nothing in the language of the McCarran Act or in its legislative history to support the thesis that the Act does not apply when the state's scheme of regulation has not been effectively enforced.

451 F.2d at 1184. *See also, Seasongood v. K & K Ins. Agency*, 548 F.2d 729, 734 (8th Cir. 1977); *Commander Leasing Co. v. Transamerica Title Ins. Co.*, 477 F.2d 77, 84 (10th Cir. 1973); *Meicler v. Aetna Cas. & Sur. Co.*, 372 F. Supp. 509, 513 (S.D. Tex. 1974), *aff'd*, 506 F.2d 732 (5th Cir. 1975).

This general principle has been applied to cases involving health insurance programs. Although some

states specifically authorize regulation of provider contracts, such detailed regulation is not required to invoke the protection of the Act. In *Western Health Care Corp. v. Colorado Hosp. Serv.*, CA No. 76 M 760 (D. Colo. Feb. 16, 1977), the court held that a contract between the Plan and the hospital was within the scope of the exemption where the Plan was regulated by a Nonprofit Hospital Act which gave the insurance commissioner "general authority to investigate and regulate" the Plan. No. 76 M 760, slip opin. at 5. In *St. Bernard Gen. Hosp. Inc. v. Hospital Serv. Ass'n of New Orleans*, 1978-1 Trade Cas. (CCH) ¶61,868 (E.D. La. 1977), the court held that provider agreements were part of the "business of insurance" and exempt from the federal antitrust laws where the underlying insurance contracts had been approved by the Commissioner of Insurance even though the provider agreements had not been specifically approved. ¶61,868 at 73,636.

Regardless of the precise contours of a state's particular regulatory system, this Court has acknowledged the intent of Congress to exempt all such systems from the federal antitrust laws to the extent they regulate the "business of insurance":

> Moreover, in taking this action Congress must have had full knowledge of the nationwide existence of state systems of regulation and taxation; of the fact that they differ greatly in the scope and character of the regulations imposed and of the taxes enacted; and of the further fact that many, if not all, include features which, to some extent, have not been applied generally to other interstate business. Congress could not have been unacquainted with these facts and its purpose was evidently to throw the whole weight of its power behind the state systems, notwithstanding these variations.

Prudential Ins. Co. v. Benjamin, 328 U.S. 408, 430 (1946). Aware of the variety of state regulation of the insurance business, Congress did not intend to require a particular kind of regulation to exempt insurance under the McCarran-Ferguson Act.

D. Application Of The Federal Antitrust Laws To Insurer-Provider Agreements Would Impair State Regulation Of Insurance.

The Fifth Circuit's decision subjects one aspect of the insurance business, the insurer-provider agreements, to the federal antitrust laws while exempting another integrally related aspect of the insurance business, the insurer-insured relationship, from the same laws. Thus, the health insurer's business would become subject to two potentially conflicting sets of rules, *i.e.*, those embodied in the state insurance commissioner's regulatory policies versus those in the federal antitrust laws. Such a conflict would not only interfere with state regulation of the insurer-provider and insurer-insured relationships, but would also impair the health insurer's compliance with state regulation of the two relationships.

The Fifth Circuit's decision would effectively deprive the state of its ability to develop and apply a combination of regulatory systens which in its view will best provide reasonable cost health insurance for its citizens. The McCarran-Ferguson Act, by designating the states as the primary insurance regulators in the absence of any federal law which "specifically relates to the business of insurance," left this policy decision to the states. Accordingly, some states decided to pursue the objective of reasonable cost health insurance entirely through special insurance statutes administered by their insurance commissioners without applying their antitrust laws to the insurance industry. *See, e.g.*, Ill. Rev. Stat. 1975, ch. 38, § 60-5(4); Hawaii Rev. Stat. § 480-11(b) (1968); Md. Code Ann. C.L. § 11-203(4) (1975); N.J.

Stat. Ann. § 56:9-5(b)(4) (Supp. 1977). Other states chose to enact special unfair competition statutes applicable to the insurance industry which permit the insurance commissioner to decide on a case-by-case basis whether the application of antitrust principles to a particular insurance activity will advance the objective of reasonable cost health insurance for its citizens. *See, e.g., FTC v. National Cas. Co.*, 357 U.S. 562, 564 n. 6 (1958); *Addrisi v. Equitable Life Ins. Soc'y of United States*, 503 F.2d 725, 728 (9th Cir. 1974), *cert. denied*, 420 U.S. 929 (1975); *Commander Leasing Co. v. Transamerica Title Ins. Co.*, 477 F.2d 77, 83 (10th Cir. 1973). Still other states decided that wholesale application of their antitrust laws to all insurance activities will best achieve the objective of reasonable cost health insurance. *See, e.g., Steingart v. Equitable Life Assur. Soc'y of United States*, 366 F.Supp. 790, 793-794 (S.D.N.Y. 1973); *California League of Indep. Ins. Prod'rs v. Aetna Cas. & Sur. Co.*, 175 F.Supp. 857, 860 (N.D. Cal. 1959).

Under the Fifth Circuit's decision, a state insurance commissioner could not authorize its health insurers to enter into certain arrangements with providers which, though containing costs, might conceivably raise questions under the federal antitrust laws even though the state found that this was the best way to provide reasonable cost, comprehensive health insurance for its citizens. For example, in *Travelers Ins. Co. v. Blue Cross of Western Pa.*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973), the court noted that, in order to reduce costs, the insurance commissioner had approved a provider reimbursement contract with the Plan which had been "negotiated jointly" by competing hospitals. 481 F.2d at 84.

Moreover, the Fifth Circuit's decision would necessarily affect the states' ability to regulate the insurer-

insured relationship, a relationship which this Court has previously characterized as the very "core" of the "business of insurance." *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969). The Fifth Circuit concedes that some states may have to raise premium rates to accommodate the increase in costs resulting from its decision. 556 F.2d at 1382.

In addition, the Fifth Circuit's decision would place the insurer in the untenable position of attempting to comply with two potentially conflicting regulatory policies. Many insurers would find that their cost containment efforts were to be guided by the federal antitrust laws, while their rates and benefits would have to be tailored to other, potentially inconsistent, rules promulgated by the states.

For example, notwithstanding the Fifth Circuit's decision, a state might still decide that its interest in providing reasonable cost health insurance to its citizens is best served by the insurance commissioner's regulation of the insurer-insured relationship. Accordingly, the state insurance commissioner might direct an insurer to charge a rate or provide a particularly comprehensive scope of benefits which would not be economically feasible without vigorous cost containment efforts which might conceivably raise questions under the federal antitrust laws. If the federal antitrust laws prohibited the insurer from making these efforts, the insurer might have to resign itself to a continuous loss of money and eventual financial insolvency, unless and until the insurance commissioner permitted an increase in rates in order to accommodate increases in costs.

II.

THE PHARMACY AGREEMENTS PROMOTE COMPETITION, IN ACCORDANCE WITH THE FEDERAL ANTITRUST LAWS.

The Fifth Circuit's construction of the "business of insurance" appeared to be influenced by its view of the merits of the case with regard to the antitrust issues. In particular, the Fifth Circuit stated that the pharmacy agreements "do not require Blue Shield to fix prices or to produce other anticompetitive effects in the pharmaceutical industry." 556 F.2d at 1381. Thus, the court implied that the "business of insurance" does not include violations of the federal antitrust laws. Such reasoning would render the entire McCarran-Ferguson Act meaningless by exempting from the federal antitrust laws only activities which do not violate the federal antitrust laws. *Cf. Dexter v. Equitable Life Ass. Soc'y of United States*, 527 F.2d 233, 236 (2d Cir. 1975).

Even if the legality of the agreements under the federal antitrust laws had any legitimate bearing on the scope of the phrase "business of insurance,"* the pharmacy agreements unquestionably withstand the scrutiny of the federal antitrust laws. Indeed, the Plans designed the reimbursement formula in the pharmacy agreements to allow the interplay of market forces in the retail drug industry to determine the cost of

* Of course, to the extent that such agreements constitute boycott, coercion or intimidation, Section 1013(b) of the McCarran-Ferguson Act would not exempt them from the federal antitrust laws. 15 U.S.C. § 1013(b). The Fifth Circuit, however, did not discuss the applicability, if any, of the "boycott exception."

The court below suggests that if the McCarran-Ferguson Act were inapplicable the federal antitrust laws would be fully applicable. Any such conclusion appears to be erroneous for a number of different reasons: *e.g.*, under principles articulated by this Court in *Parker v. Brown*, 317 U.S. 341 (1943), and related cases, the federal antitrust laws might not apply if state regulatory authorities mandated, approved, encouraged or otherwise participated in the challenged activities.

prescriptions. The Department of Justice has repeatedly taken the position that such agreements do not violate the federal antitrust laws.

A. Blue Shield's Pharmacy Agreements Were Designed To Permit The Free Play Of Market Forces To Determine The Cost Of Each Prescription.

As discussed in the introductory section of this memorandum, the total reimbursement to the participating pharmacy consists of the acquisition cost of the drug, plus the dispensing fee, minus the deductible, if any. The acquisition cost is determined by market forces in the wholesale drug industry and is not affected by the pharmacy agreements. The deductible, though initially determined through negotiation between the insurer and the insured, can subsequently be discounted by individual participating pharmacies. The dispensing fee is merely a unilateral offer from the Plan to each pharmacy to provide services for a specified price. Since the plaintiffs complain bitterly about the inadequacy of the dispensing fee (Respondents' Brief in Opposition to Certiorari at 5-13), a description of its history, background and operation may be useful.

Several years before the drug programs were initiated, two courts had ruled that concerted action by pharmacists which had the intent and effect of fixing retail prescription drug prices violated Section 1 of the Sherman Act. *Northern California Pharm. Ass'n v. United States*, 306 F.2d 379 (9th Cir.), *cert. denied*, 371 U.S. 862 (1962); *United States v. Utah Pharm. Ass'n*, 201 F. Supp. 29 (D. Utah 1962). In light of these decisions, the Plans decided to determine the amount of the dispensing fees unilaterally and to let the market accept or reject the offers. *1971 Hearings* at 298 (testimony of Waldo A. Stevens).

In 1969, Lewis Bernstein, Chief of the Special Litigation Section of the Antitrust Division, agreed with the Plans' interpretation of these cases. He told retail pharmacists that they could not bargain collectively with insurers over the amount of the dispensing fee or make a collective decision about whether to accept or reject the offers without violating the antitrust laws under the principles of *Northern California Pharmaceutical* and *Utah Pharmaceutical*. However, as he went on to explain, these prohibitions did not leave the druggists without bargaining power. Mr. Bernstein said:

> Additionally, the interest of the several plans in preserving existing channels of drug distribution compel them to carefully consider adequate compensation for the druggist. The individual druggist's reaction to the fee offered must be considered in developing the plan. Here is why. Most plans will be developed as a result of demands upon employers by their employees to include prepaid prescription drugs in the health benefit plans which they furnish. In turn, the employers will pass their requirements along to their insurance carriers. The carriers must develop plans that will satisfy the employees or the employer will seek another carrier that will. To satisfy the employee the plan must afford them the ability to get their prescriptions filled readily in their neighborhood drug stores. No plan will have the member's support if it obligates him to travel distances to get his prescriptions filled in emergencies. Consequently, the insurance carrier is compelled to offer a dispensing fee that it believes will be acceptable to the individual druggist. If it does not, it runs the risk that sufficient number of individual pharmacists will reject the plan. This will induce the employer to seek another insurance carrier to satisfy the demands of the union.

Bernstein, *Antitrust Aspects of Prepaid Prescription Plans* 10, 11 (address to Annual Convention of National Ass'n of Retail Druggists, Las Vegas, Nev., Oct. 15, 1969) (mimeo).

Mr. Bernstein's analysis is borne out by an examination of the development of the UAW program. In 1967, the Michigan Plan became obligated to implement the prescription drug program agreed to in the UAW-auto industry labor contract. To do this effectively, it had to get a large number of pharmacists to agree to participate. *1973 Hearings* at 103-04 (testimony of Donald G. Puscas). Because the program would account for only a small part of the existing retail drug sales, the Plan had to offer a dispensing fee which equaled the market value of the pharmacists' services. However, the Michigan program was the first major undertaking of its kind and there was no separate market price for such a dispensing fee.

The Plan therefore undertook an extensive study of current prices and published data on retail pharmacy operations and costs in Michigan. *Id.* at 104. Based on this study, the Michigan Plan found that the average gross margin on retail prescription drugs, including expenses for salaries and overhead and return on investment, was approximately 46 percent. Applying this figure to the average price of a prescription drug sale yielded an average "dispensing fee" of $1.80 per prescription. *Id.* Because the study used actual data, these calculations took account of the cost of providing the customary level of service (including the cost of record-keeping, delivery, emergency and consulting services) for most pharmacies. *Id.* at 105. To account for inflation between the time of the study and July 1969 when the program was to begin, as well as to establish a price which would be valid for a reasonable time thereafter, the Plan decided to offer an initial fee of $2.00 to pharmacists in the State of Michigan. *Id.* at 104. The

satisfactory initial response to this offer indicated that the Michigan Plan had in fact offered a good deal. *Id.* at 109.

Reviewing these developments in 1973, Donald G. Puscas, Executive Vice President of the Michigan Plan, testified before a House Subcommittee that the Plan's objective had been to offer a dispensing fee which reflected existing and customary charges, and satisfied the variable needs of many types and sizes of businesses. *Id.* at 105. The Plan had no intention to affect the market price; rather, the Plan's goal was to see that, on average, pharmacists would neither gain nor suffer by participating. The objective was to have the market continue to behave as if no program existed. *Id.* at 208, 213. At that time, Bruce B. Wilson, Deputy Assistant Attorney General of the Antitrust Division, and Barry Grossman, Chief of the Evaluation Section, again explained, as Mr. Bernstein had earlier, that the constraints of the market in which the programs operated inevitably required insurers to do exactly what the Michigan Plan had accomplished. *Id.* at 61.

Nevertheless, the plaintiffs in the instant lawsuit attempt to support their assertion that they are "coerced" into accepting inadequate compensation from the Plan by comparing the dispensing fee with drug acquisition costs which range from $8 to $80. Respondents' Brief in Opposition to Certiorari at 6. This is misleading. According to one survey based on pharmacies in New York, Vermont, Massachusetts and Pennsylvania, the average cost of a prescription purchased at a retail pharmacy in 1976 was $5.22, and more than 70 percent of retail prescriptions cost less than $6.00 in that year.*

* The 1976 average prescription price nationwide was about $5.66. Eli Lilly & Co., *Lilly Digest: A Survey of Community Pharmacy Operations for 1976* 26 (1977).

De Nuzzo, *Annual Prescription Survey by the Albany College of Pharmacy*, Med. Marketing & Media 32, 40 (April 1977). Dispensing fees offered by Blue Shield and Blue Cross Plans in 1976 ranged from $1.85 to $3.11 in various states, with only four Plans offering less than $2.00. Blue Cross Ass'n-Blue Shield Ass'n, *Out-of-Hospital Prescription Drug Data for 1976* 20-27 (July 1977) (internal report). Based on these figures, one may conclude that the dispensing fee normally represents at least a 50 percent markup over the acquisition cost of drugs used for a typical prescription. Plans have periodically adjusted their dispensing fees to continue to attract a sufficient number of participating pharmacies. *See, e.g., Drug Topics* 28 (Sept. 1, 1977); *Am. Druggist* 25 (Sept. 1977).

Dispensing fees offered to participating pharmacists by the states under the Medicaid program are lower than those offered by the Plans. In 1976 they ranged from $1.24 to $2.86 with more than ten states paying less than $2.00. *Medicaid Fee Freeze Affects Nearly Half the States*, Drug Topics 13 (Aug. 1, 1977). Medicaid purchases account for about 8 percent of total retail drug sales, Gibson & Mueller, *National Health Expenditures Fiscal Year 1976*, 40 Soc. Sec. Bull. 3 at 9, 11 (April 1977), while Plan programs account for about two percent. *Id.* at 9; Mueller, *Private Health Insurance in 1975: Coverage, Enrollment, and Financial Experience*, 40 Soc. Sec. Bull. 3 at 7, 14 (June 1977). Accordingly, the economic woes of the independent pharmacists who are plaintiffs in this case can scarcely be attributed to "unfair" and "coercive" fees offered by the Plans. In fact, a recent study attributed the independents' economic problems to their refusal to participate in Medicaid programs and to offer prices as attractive as "chain" stores. Feierman & Kushner, *Chain Rx Departments Outpace Independents*, Am. Druggist 47, 50 (May 1977).

B. The Department Of Justice Has Followed The Development Of Prepaid Prescription Drug Programs, Repeatedly Stating That They Do Not Violate The Federal Antitrust Laws.

The Antitrust Division has regularly scrutinized prepaid drug insurance programs and has never alleged that the pharmacy agreements violate the antitrust laws. In the latter part of 1967, the Department of Justice, following its Business Review Procedure, reviewed a prescription drug program proposed by the Kansas Physicians' Service (Kansas Blue Shield) which contained a similar reimbursement provision and provided for participating pharmacy agreements like the ones challenged in this case. (Appendix D hereto.) The Department of Justice advised the Kansas Plan in January 1968 that it did not intend "to initiate any proceedings under the federal antitrust laws to prevent placing the plan into effect." (Appendix E hereto.) In October 1968, the Department of Justice issued a similar letter to another prescription drug program which offered to reimburse contracting pharmacists for the acquisition costs plus a dispensing fee. Like the Plan programs, the dispensing fee in that program was to be calculated unilaterally by the intermediary, and no concerted price action by pharmacists was contemplated. (Appendix F hereto.)

In addition to the foregoing formal review procedures, subsequent statements of Department of Justice officials indicate that they have monitored the development of prepaid drug programs and have found the pharmacy agreements to be completely lawful under the antitrust laws. In 1971 a Department of Justice spokesman told a House Subcommittee that the pharmacy agreements did not violate the antitrust laws as long as pharmacists did not participate as a group in negotiating the amount of

the dispensing fee. *1971 Hearings* at 230-31 (statement of Bruce B. Wilson).

Thereafter, at the request of some retail pharmacists, the House Subcommittee on Environmental Problems Affecting Small Business requested an extensive study of the operation of the prescription drug programs. This was done by an inter-agency committee formed by the Department of Health, Education, and Welfare in which the Department of Justice participated. *1973 Hearings* at 52. After the committee had completed its work, the Department of Justice again stated that "it is our . . . policy not to challenge programs where the carrier makes a unilateral offer to the pharmacies." *Id.* at 56.

CONCLUSION

BSA urges this Court to reverse the decision of the Fifth Circuit. The court below misunderstood the realities of today's health insurance market and the operation of the Plans' prepaid prescription drug programs. Numerous state and federal regulatory and judicial authorities have declared that cost containment, because of its integral relation to rates and premiums, is a fundamental aspect of the "business of insurance." The Department of Health, Education, and Welfare and various other government agencies have recognized the proven ability of these pharmacy agreements (and the reimbursement formula contained therein) to help control the escalating cost of health insurance.

The Fifth Circuit held, in essence, that cost containment has no place in the "business of insurance." The decision below would subject insurers to the vagaries of

potentially conflicting state and federal regulatory policies and would undermine the states' role as the primary regulators of the "business of insurance." This result is particularly unwarranted because the challenged drug program clearly does not violate the federal antitrust laws. Indeed, the public record shows that the program was specifically designed to allow the free interplay of market forces to determine the cost of prescriptions.

In sum, BSA respectfully submits that the decision of the Fifth Circuit should be reversed because cost containment efforts, such as the pharmacy agreements in this case, are a fundamental part of the "business of insurance" and are entitled to the full protection of the McCarran-Ferguson Act.

Respectfully submitted,

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Attorneys for
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Dated: May 13, 1978

APPENDIX

APPENDIX A

(*Letterhead Of*)

LAW OFFICES OF

COX, SMITH, SMITH, HALE & GUENTHER
INCORPORATED
SAN ANTONIO, TEXAS 78205

April 10, 1978

Mr. Michael Rodak, Jr.
Clerk, Supreme Court of the
United States
1 First Street, N.E.
Washington, D.C. 20543

Re: 77,952, *Group Life and Health Insurance Company, et al. v. Royal Drug Company, et al.*

Dear Mr. Rodak:

Petitioners and Respondents hereby consent to the filing of all briefs *amicus curiae* in the above captioned case. Please file this blanket consent in the records of this proceeding.

Sincerely,

/s/ KEITH E. KAISER
For All Petitioners

/s/ JOEL H. PULLEN
For All Respondents

APPENDIX B

BLUE SHIELD PLANS IN THE UNITED STATES

Blue Shield Plans are located throughout the United States. The Plans' principal offices are located in the following cities:

Birmingham, Ala.	Jamestown, N.Y.
Phoenix, Ariz.	New York, N.Y.
Little Rock, Ark.	Rochester, N.Y.
San Francisco, Calif.	Syracuse, N.Y.
Denver, Colo.	Utica, N.Y.
New Haven, Conn.	Durham, N.C.
Wilmington, Del.	Fargo, N.D.
Washington, D.C.	Cleveland, Ohio
Jacksonville, Fla.	Worthington, Ohio
Atlanta, Ga.	Tulsa, Okla.
Columbus, Ga.	Portland, Ore.
Honolulu, Hawaii	Camp Hill, Pa.
Boise, Idaho*	Providence, R.I.
Lewiston, Idaho	Columbia, S.C.
Chicago, Ill.	Sioux Falls, S.D.
Indianapolis, Ind.	Chattanooga, Tenn.
Des Moines, Iowa	Memphis, Tenn.
Topeka, Kansas	Dallas, Texas
Louisville, Ky.	Salt Lake City, Utah
Portland, Maine	Richmond, Va.
Baltimore, Md.	Roanoke, Va.
Boston, Mass.	Bremerton, Wash.
Detroit, Mich.	Seattle, (King), Wash.
St. Paul, Minn.	Seattle (WPS), Wash.
Jackson, Miss.	Spokane, Wash.
Kansas City, Mo.	Tacoma, Wash.
St. Louis, Mo.	Wenatchee, Wash.
Helena, Mont.	Charleston, W. Va.
Omaha, Neb.	Clarksburg, W. Va.
Reno, Nev.	Morgantown, W. Va.
Concord, N.H.	Parkersburg, W. Va.
Newark, N.J.	Wheeling, W. Va.
Albuquerque, N.M.	Madison, Wis.
Albany, N.Y.	Milwaukee, Wis.
Buffalo, N.Y.	Cheyenne, Wyo.

* Became member of Blue Shield Association on March 22, 1978.

APPENDIX C

Prototype Agreements

Out-of-Hospital Prescription Drug Service
Co age Rider (as amended by BCA
Board of Governors on February 10, 1969.)

NOTE: This is a draft of a Rider intended for use with a master group contract to supplement the basic benefits provided thereunder with additional benefits for out-of-hospital prescription drugs. The same terms and conditions may be incorporated in an endorsement to the Subscriber certificate.

Employer Contract No. Rider No. Effective Date

IT IS AGREED that in consideration of the charges stated in the referenced Contract, this Rider is issued to the Employer named hereon and forms a part of said Contract on the above Effective Date.

ARTICLE I—DEFINITIONS

1. "PHARMACY" means any licensed establishment wherein the profession of pharmacy is practiced.

2. "PHYSICIAN" means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is legally licensed, without limitation, to practice medicine and perform surgery. For benefits covered by this Rider, and for no other purposes, Doctors of Dental Surgery (D.D.S.) and Doctors of Dental Medicine (D.M.D.) and Doctors of Surgical Chiropody (D.S.C.) when acting within the scope of their licenses are deemed to be Physicians.

3. "PRESCRIPTION DRUGS" means (a) any medication which by federal or state law may not be dispensed without a prescription and (b) insulin.

4. "PRESCRIPTION ORDER" means the request for medication issued by a physician duly licensed to make such a request in the ordinary course of his professional practice.

5. "PARTICIPATING PROVIDER" means any Pharmacy which or any Physician who regularly dispenses Prescription Drugs and has entered into a Participation Agreement with this Plan or any other Participating Blue Cross or Blue Shield Plan.

6. "NON-PARTICIPATING PROVIDER" means any Pharmacy other than a Participating Provider and any Physician other than a Participating Provider who regularly dispenses Prescription Drugs.

7. "PARTICIPATING PLAN" means any Blue Cross or Blue Shield Plan or other affiliate which has agreed in writing to provide to Subscribers, in whole or in part, benefits described in this Rider.

8. "DEDUCTIBLE" means the amount of $_____($.50, $.75, $1.00 or $1.25—here insert the amount chosen by account) which shall be applied against each Prescription Drug or refill thereof dispensed.

ARTICLE II BENEFITS PROVIDED

1. In addition to the benefits provided under the Contract, benefits shall be available for Prescription Drugs dispensed pursuant to a Prescription Order for the out-of-hospital use of the Subscriber or his Dependent covered under this Rider so long as the same is in effect, subject to the applicable deductible, if any, as follows:

(a) From a Participating Provider: The Participating Provider will furnish such Prescription Drugs and will not make any charge or collect from the Subscriber any amount which exceeds the deductible amount set forth in this Rider.

(b) From a Non-Participating Provider of this Plan or any other Participating Plan: the Subscriber shall be entitled to reimbursement from the Plan in

an amount not to exceed 75% of the Provider's usual and ordinary charges as determined by the Plan, after the deductible, if any, has been applied.

(c) From a Non-Participating Provider in a Non-Participating Plan area: the Subscriber shall be entitled to 100% of such Provider's usual and ordinary charges as determined by the Plan, less the deductible, if any.

2. The benefits under this Rider shall be provided to the extent practicable in the form of service, and payment therefor by or on behalf of the Plan shall constitute a complete discharge of the obligations of the Plan to the extent of the service rendered in accordance with the terms and conditions of this Rider. The Plan shall indemnify the Subscriber directly for that part of the benefits which are not provided in the form of service in accordance with the terms and conditions hereof and reserves the right to indemnify the Subscriber directly for all benefits provided herein.

ARTICLE III—LIMITATIONS

1. A Participating or Non-Participating Provider need not dispense a Prescription Order which for any reason, in his professional judgment, should not be filled.

2. The quantity of Prescription Drugs dispensed pursuant to an original Prescription Order shall be limited to a supply of thirty-four (34) consecutive days, except that _____
(this blank to be completed by naming certain drugs or classes of drugs from those listed in the attachment, as determined by the national account with the Control Plan, including the present combination of natural thyroid products and nitroglycerine as now provided in Article III, paragraph 2 of the June 14, 1967 approved rider) may be distributed in quantities up to 100 unit doses for each prescription.

3. Refills shall be dispensed only pursuant to a Prescription Order and shall be subject to the same

limitations as contained in Paragraph 2 above. If the number of refills is not specified in the Prescription Order, refills will not be provided beyond one year from the original prescription date.

4. This Rider carries no conversion privilege.

ARTICLE IV—EXCLUSIONS

In addition to the exclusions in the Contract, no benefits shall be provided for:

1. Other than Prescription Drugs such as contraceptive devices, therapeutic devices, artificial appliances, hypodermic needles, syringes or similar devices.

2. Administering or injecting Prescription Drugs.

3. Any contraceptive medication, even if such medication is a Prescription Drug.

ARTICLE V—CONDITIONS UNDER WHICH SERVICE SHALL BE RENDERED

1. The Subscriber's identification card shall be presented to the Participating Provider when the Subscriber or Dependent applies for benefits under this Rider.

2. As a condition precedent to the approval of claims hereunder, each Subscriber and Dependent authorizes and directs and [*sic*] Provider who furnished benefits hereunder to make available to the Plan information relating to all Prescription Orders, copies thereof and other records as needed by the Plan. The Plan shall in every case hold such information and records as confidential.

3. The Plan shall not be liable for any claim or demand for injury or damage arising out of or in connection with the manufacturing, compounding, dispensing, or use of any Prescription Drug whether or not covered under this Rider.

Classes of Drugs which may be obtained as paid benefits in quantities up to 100 unit doses.

Antiarthritic Drugs
Anticoagulants
Anticonvulsants
Antidiabetics
Antifungal
Antihistamine
Cardiac Drugs
Diaretics
Hormones
Hypotensive
Anticholinergic and Parasympatholytic
Nitroglycerine
Vitamins Bearing Legend
Thyroid Preparations
Urinary and Intestinal Anti-Infectives
Phenobarbital
Contraceptives (where applicable)

N.B. Intent to keep with current practice.
In many cases: 100 = 34-day supply.

Specimen Participating Provider Agreement

6/14/67

NOTE: This is a draft of a prototype agreement with a Participating Pharmacy. A similar agreement will be required where a physician or dentist is the participating provider of services. It is contemplated that the benefits to which a Subscriber is entitled will be communicated to the pharmacy (or other provider) by furnishing a copy of the Subscriber certificate or instruction booklet.

THIS AGREEMENT made this ____ day of _____, 19___, by and between ____(Plan)____, hereinafter referred to as "Plan," and ____(Pharmacy)____, hereinafter referred to as "Pharmacy," doing business as a pharmacy under pharmacy permit No. _____ and located at _____.

1. The Pharmacy represents that it has a current valid permit issued by the ____(name of state)____ State Board of Pharmacy and that it is conducted as a (Note: If a partnership, the partners' names will be enumerated; if a sole proprietorship, the owner's name will be stated; and if a corporation a statement that the signatory is duly authorized to sign and will provide a copy of the articles of incorporation and by-laws).

2. The Plan agrees that it will furnish to all eligible Subscribers an identification card which the Subscriber must present to the Pharmacist in order to obtain services. The Pharmacy agrees to provide to a properly identified Subscriber the prescription drugs, required by the prescription orders which are covered benefits under the Subscriber's Out-of-Hospital Prescription Drug contract with this Plan or any other Participating Blue Cross or Blue Shield Plan or affiliate. The Pharmacy may not charge or collect from the Subscriber any amount which exceeds the deductible amount set forth in such contract.

3. The Pharmacist need not dispense a prescription order which for any reason, in his professional judgment, should not be filled. The Plan shall have the sole right, subject to the above, to determine the individuals eligible for benefits to be furnished by the Pharmacist and for which the Pharmacist is to be reimbursed.

4. The Pharmacy agrees to submit promptly to the Plan on forms provided by the Plan such information as the Plan deems necessary to identify the Subscriber and the benefits provided. The Plan agrees, within _____ ( ) days after receiving such form, to pay to the Pharmacy as reasonable compensation for the benefits provided an amount equal to the Pharmacy's acquisition cost of the pharmaceutical product or ingredient plus a dispensing fee of _____ dollars and _____ cents ($_____) for each prescription order filled. Acquisition cost means the actual billed and paid cost of the pharmaceutical product or ingredient to the Pharmacy, reflecting all discounts.

5. The Plan or its duly authorized agents shall have free access during regular business hours upon reasonable notice and demand to such books, records and prescription files of the Pharmacy as may be necessary to perform an audit following generally accepted auditing procedures. It is understood that any information obtained during such audits shall be held confidential by the Plan. Such audits may be made at any time during the term of this Agreement and within one year after its expiration.

6. It is understood and agreed that the Pharmacy may enter into agreements involving other prescription drug programs.

7. The Plan retains the exclusive right to name _____ (here insert Blue Cross and/or Blue Shield) and the _____ symbol, together with any distinctive trademark or service mark that may hereafter be adopted. The Pharmacy agrees not to advertise to the public that it is a participating member of the Plan nor to use the names, symbols, or trademarks of _____ in any manner without the prior written

consent of the Plan. Upon any termination of this Agreement, the Pharmacy will immediately discontinue the use of such names, symbols, or trademarks and forthwith return any signs, placques, insignias, displays, or any other materials indicating its participating member status.

8. The Plan shall not be liable for any claim or demand for injury or damage arising out of or in connection with the manufacturing, compounding, dispensing, or use of any prescription drug whether or not covered under this Agreement and/or the Subscribers Out-of-Hospital Prescription Drug Rider, and the Pharmacy agrees to hold the Plan harmless against any and all such claims or demands.

9. This Agreement may be terminated by either party on _____ ( ) days prior written notice. However, during said _____ ( ) day period, this Agreement and the obligations hereunder shall remain in full force and effect. The Plan, notwithstanding the above, reserves the right to cancel this Agreement at any time by written notice for cause, whereupon the Pharmacy's membership shall terminate forthwith. This right of immediate cancellation shall not in any way affect the Plan's other rights enumerated under this Agreement. This Agreement shall remain in effect notwithstanding any notice of change or adjustment in the Dispensing Fee set forth in Paragraph 4 herein, unless the Pharmacy gives written notice of its election to terminate.

10. No person, agent, or officer of the Plan is authorized to alter or vary the terms hereof, nor to make any representation or inducements relative thereto other than those specifically set forth herein. This Agreement represents the complete and total understanding of the parties.

Signed and sealed this ____ day of ____, 19 ___.

Pharmacy Name (Seal)	(Plan)
by _____	by _____
Title	Title

APPENDIX D

Application by Kansas Physicians' Service, a nonprofit corporation, commonly known as Kansas Blue Shield—Business Review Procedure—proposed prepaid prescription drug prepayment plan, August 30, 1967:

(Letterhead Of)

GOODELL, CASEY, BRIMAN,
RICE & COGSWELL

August 30, 1967

Assistant Attorney General's Office
Antitrust Division
Department of Justice
Washington, D. C. 20530

Gentlemen:

In re: Application by Kansas Physicians' Service, a non-profit corporation, commonly known as Kansas Blue Shield—Business Review Procedure—proposed prepaid prescription drug prepayment plan

We are the attorneys for Kansas Physicians' Service, commonly known as Kansas Blue Shield. Please consider this letter as the application of our client for a review of a proposed Blue Shield prescription drug prepayment program, under your Business Review Procedure for an advance clearance as to whether or not your Department will waive its right to institute criminal proceedings under the antitrust laws.

I am enclosing, herewith, the following documents:

(1) Proposed Agreement to be issued by Kansas Blue Shield to its subscribers providing prescription medications coverage and designated as "Full Pay Plan."

(2) Proposed Agreement to be issued by Kansas Blue Shield to its subscribers providing prescription medications coverage and designated as "Shared Pay Plan."

(3) Proposed Agreement to be executed by Kansas Blue Shield and individual Pharmacists who elect to become a participating pharmacy under the prepaid drug plan.

The above documents are all operative documents proposed for issuance by Blue Shield to implement the plan. Kansas Physicians' Service, commonly known as Kansas Blue Shield, is a non-profit corporation, incorporated under the provisions of the non-profit Medical Service Corporation Act of Kansas. I am enclosing, herewith, a copy of the non-profit Medical Service Corporations Act of Kansas for your review and assistance in determining the matter. I am also enclosing one copy of an Opinion issued by the Attorney General of Kansas, dated April 21, 1965, holding that Kansas Physicians' Service has the authority to issue Dental coverage plans under the provisions of K.S.A. 40-1902, which reads in part as follows:

> "Such corporations heretofore or hereafter organized may also provide service or indemnity for *other health services* but not to exceed reasonable and customary charges that a subscriber may incur for these services." (emphasis added)

Kansas Blue Shield proposes to issue the prepaid drug plan under the authority of the above quoted section which allows the issuance of such plan "for other health services."

In general, the proposed drug prepayment plan will be issued to citizens of the State of Kansas who elect to pay the premium determined by Kansas Blue Cross-Blue Shield to be necessary to allow this coverage. A subscriber may elect to have any prescription filled at any pharmacy of his choice. In the event that the subscriber has coverage under the "Full Pay Plan," eligible prescriptions will be filled by either a participating or a non-participating Pharmacist selected by the subscriber. In the event that the Pharmacist is a participating Pharmacist, the subscriber will provide proof of coverage under this agreement, to the Pharmacist. The participating Pharmacist will then, under the terms of his agreement with Kansas Blue Shield, receive from Kansas Blue Shield an amount equal to the Pharmacist's actual acquisition cost of the prescription medication (as defined in the policy) and a dispensing fee of $2.00. In the event that the subscriber elects to have the prescription filled at a non-participating pharmacy, the subscriber will pay the amount direct to the Pharmacist and then make a claim to Blue Shield. Kansas Blue Shield will provide an indemnity of an amount not to exceed 75% of the usual and customary charge of the Pharmacy, or 75% of the amount a participating pharmacy would have charged for the same prescription, whichever is the lesser.

The procedure for the proposed "Shared Pay Plan" in general is identical except for the amount to be paid by Kansas Blue Shield. In the "Shared Pay Plan" the participating pharmacist will charge the subscriber 50% and Blue Shield will pay to the participating pharmacist the remaining 50% of the charge for the prescription. Under the "Shared Pay Plan," the subscriber will pay the full charge of the non-participating pharmacist, and the subscriber will be entitled to an indemnity of an amount not to exceed 50% of 75% of the usual and customary charges of the non-participating pharmacist, or 50% of 75% of the amount paid to a participating pharmacy for the same prescription, whichever is lesser.

In general, the above summarizes the proposed plan of business conduct maintained by Kansas Physicians' Service. In the event that you need any additional information or documents, please advise and the same will be furnished immediately.

If possible, we hope that your office can review the proposed plan and issue an opinion under the Business Review Procedure at the earliest possible time, hopefully by Sep-

tember 15, 1967. If it is not possible to secure an opinion by that date, we would appreciate receiving your best estimate as to the time required.

Very truly yours,
/s/ Gerald L. Goodell
Of Goodell, Casey, Briman, Rice & Cogswell

GLG :mh
Encs.
cc Blue Cross-Blue Shield

FULL PAY PLAN

Kansas Blue Shield

PRESCRIPTION MEDICATIONS RIDER

Out-Of-Hospital Only

ARTICLE I. GENERAL PROVISIONS

A. This is a Rider to a Contract or Certificate issued by Kansas Physicians' Service, Topeka, Kansas, a non-profit corporation known as Kansas Blue Shield. The appropriate terms and provisions of the Kansas Blue Shield Contract or Certificate to which this Rider is attached apply except as otherwise specified in this Rider.

B. This Rider is issued for attachment to the Kansas Blue Shield Contract or Certificate and becomes effective for the Subscriber on the Benefit Date shown on the Identification Card.

ARTICLE II. DEFINITIONS

The following definitions are added to Article I, Definitions, of the Contract or Certificate:

A. *Prescription Order* is the request for medication issued by a duly licensed physician, dentist, or podiatrist in the authorized course of his professional practice.

B. *Prescription Charges* shall represent the acquisition cost of the drugs or medication actually used in preparation of the prescription pursuant to a Prescription Order plus a dispensing fee.

C. *Acquisition Cost* shall mean the usual and customary pricing basis but in no instance greater than the—

1. Blue Book Cost, by Manufacturer.
2. Blue Book Cost, by Manufacturer, shall be determined as follows:
   a. Readymade Capsules, Pills, Tablets, and similar Substance—Cost per 100 units.
   b. Readymade Liquids—Cost of 16 ozs.
   c. Readymade ointments and powders dispensed from bulk package—Cost per pound.
   d. Originals—Ear Drops, Eye Drops, Nose Drops, Sprays, and Ointments in tube or jar —Cost of Package.
   e. Injectables—Cost of Ampules—Cost of Vials.
   f. Compounded Prescription—Cost of Ingredient plus 50¢.

D. *Dispensing Fee* means the fixed amount established by the Plan which is paid to the Participating Pharmacy over and above the Acquisition Cost for each Prescription Order or refill dispensed.

E. *Prescription Medications* means drugs or biologicals dispensed for human use pursuant to a Prescription Order which are legend drugs and are thus required, under the Federal Food and Cosmetic Act, to bear the legend: "Caution, Federal law prohibits dispensing without prescription." Excluded are contraceptive medications unless specifically included as an option.

F. *Participating Pharmacy* shall mean any licensed pharmacy which has entered into an agreement with the Plan to provide the pharmaceutical services listed in this Rider.

G. *Non-Participating Provider* shall mean any licensed pharmacy in Kansas which or licensed physician who, has not entered into an agreement with the Plan.

H. *Participating Contract* shall mean the agreement entered into between the Plan and the Participating Pharmacy which shall set forth their respective rights and obligations.

I. *Physician* shall mean a Doctor of Medicine or a Doctor of Osteopathy duly licensed to practice medicine or osteopathy at the time and place the service is provided.

ARTICLE III. RELATIONSHIP BETWEEN SUBSCRIBER AND PARTICIPATING PHARMACY

A. The Agreement between Kansas Blue Shield and the Participating Pharmacy may be terminated by either Kansas Blue Shield or the Participating Pharmacy at any time upon thirty (30) days' prior written notice to the other.

B. It is understood that the Pharmacy need not dispense a Prescription Order for any reason which, in the pharmacist's professional judgment, should not be honored.

ARTICLE IV. ELIGIBLE SERVICES

Charges for Prescription Medications, except for the exclusions indicated in Article V of this Rider, dispensed for use by the Subscriber or any of his eligible Dependents when the Prescription Order is requested by a licensed physician, dentist, or podiatrist in the authorized course of his professional practice.

A. Limitations:

(1) Only drugs and biologicals which are legend drugs, and are thus required, under the Federal Food and Cosmetic Act, to bear the legend: "Caution, Federal law prohibits dispensing without prescription."

(2) Refills will be covered up to one year from the date of the Prescription Order.

(3) The quantity of Prescription Drugs dispensed pursuant to an original Prescription Order shall be limited to a supply of thirty-four (34) consecutive days, except that Prescription Orders for medications whose acquisition cost is not greater than $1.00 shall be limited to 100 unit doses for each prescription.

ARTICLE V. EXCLUSIONS

A. The following exclusions apply to the benefits of this Rider in addition to the exclusions of the basic Contract or Certificate to which this Rider is attached:

1. Prescriptions written by any practitioner other than a duly licensed physician, dentist, or podiatrist in the authorized course of his professional practice.
2. The purchase of products other than drugs or biologicals, such as contraceptive or therapeutic devices, artificial appliances, etc.
3. Administration or injection of Prescription Medications.
4. Non-legend, patent, or proprietary drugs.
5. Contraceptive medications unless specifically included as an option.

B. No duplicating payment will be made under this Rider for Prescription Medications which are provided under any other Rider to the Kansas Blue Shield Contract or Certificate to which this Rider is attached.

ARTICLE VI. BENEFITS PROVIDED

A. Benefits will be available for Subscribers' expenses for Prescription Medications when dispensed by a Participating Pharmacy or by a Non-Participating Provider pursuant to a Prescription Order for the out-of-hospital use by the Subscriber or his Dependent covered under this Rider so long as the same is in effect.

At the discretion of Blue Shield, certain devices may be included if related to the use of the prescribed medication.

B. Participating Pharmacy: A Participating Pharmacy will provide the Prescription Order to the Subscriber and will make no charge to the Subscriber.

C. Non-Participating Provider: The Subscriber shall be entitled to an indemnity of an amount not to exceed 75 percent of the Provider's usual and customary charge, or 75 percent of the amount paid to a Participating Pharmacy for the same prescription, whichever is lesser.

ARTICLE VII. PRODUCT LIABILITY

Blue Shield shall not be responsible for any claims arising out of or through the manufacturing, compounding, dispensing, and use of any Prescription Medications whether covered under this Agreement or not.

ARTICLE VIII. CONDITIONS

The Subscriber's Blue Shield Identification Card shall be presented to the Participating Pharmacy when the Subscriber or Dependent applies for benefits under this Rider. The Subscriber authorizes and directs any Pharmacy or other Provider to furnish and make available to Blue Shield any Prescription Order copies for which benefits shall have been claimed on behalf of himself and enrolled dependents.

KANSAS PHYSICIANS' SERVICE
Topeka, Kansas

Attest:
Secretary

President

Form No. .....
7-14-67 rev.

SHARED PAY PLAN

(First 4 Pages same as Full Pay Plan)

ARTICLE V. EXCLUSIONS (continued)

A. 3. Administration or injection of Prescription Medications.
4. Non-legend, patent, or proprietary drugs.
5. Contraceptive medications unless specifically included as an option.

B. No duplicating payment will be made under this Rider for Prescription Medications which are provided under any other Rider to the Kansas Blue Shield Contract or Certificate to which this Rider is attached.

ARTICLE VI. BENEFITS PROVIDED

A. Benefits will be available for Subscribers' expenses for Prescription Medications when dispensed by a Participating Pharmacy or by a Non-Participating Provider pursuant to a Prescription Order for the out-of-hospital use by the Subscriber or his Dependent covered under this Rider so long as the same is in effect, subject to the shared payment agreement in paragraph D of this section. At the discretion of Blue Shield, certain devices may be included if related to the use of the prescribed medication.

B. Participating Pharmacy: A Participating Pharmacy will provide the Prescription Order to the Subscriber and will make no charge to the Subscriber other than the shared payment amount of fifty percent (50%). Blue Shield will pay to the Participating Pharmacy the remaining fifty percent (50%) of covered Prescription Charges.

C. Non-Participating Provider: The Subscriber shall be entitled to an indemnity of an amount not to exceed fifty percent (50%) of 75 percent of the Provider's usual and customary charges, or fifty percent (50%)

of 75 percent of the amount paid to a Participating Pharmacy for the same prescription, whichever is lesser.

D. The Subscriber is responsible for the payment of fifty percent (50%) of the covered Prescription Medication Charges.

ARTICLE VII. PRODUCT LIABILITY

Blue Shield shall not be responsible for any claims arising out of or through the manufacturing, compounding, dispensing, and use of any Prescription Medications whether covered under this Agreement or not.

ARTICLE VIII. CONDITIONS

The Subscriber's Blue Shield Identification Card shall be presented to the Participating Pharmacy when the Subscriber or Dependent applies for benefits under this Rider. The Subscriber authorizes and directs any Pharmacy or other Provider to furnish and make available to Blue Shield any Prescription Order copies for which benefits shall have been claimed on behalf of himself and enrolled dependents.

KANSAS PHYSICIANS' SERVICE
Topeka, Kansas

Attest:
Secretary

President

Form No. .....
7-14-67 rev.

Proposed

BLUE SHIELD CONTRACT WITH
PARTICIPATING PHARMACIES

SECTION I. DEFINITIONS

A. *Plan* means Kansas Physicians' Service, hereinafter known as Kansas Blue Shield.

B. *Subscriber* is the person, or any of his eligible dependents, with whom the Plan has entered into a contract to provide benefits.

C. *Dependent* means the spouse of the Subscriber and each eligible dependent child.

D. *Contract Holder* means any individual or organization which has agreed, on behalf of the Subscriber, to remit to the Plan the rates payable under the Subscriber's agreement.

E. *Prescription Order* is the request for medication issued by a duly licensed physician, dentist, or podiatrist in the authorized course of his professional practice.

F. *Prescription Charges* shall represent the acquisition cost of the drugs or medication actually used in preparation of the prescription pursuant to a Prescription Order plus a dispensing fee.

G. *Acquisition Cost* shall mean the usual and customary pricing basis but in no instance greater than the—

1. Blue Book Cost, by Manufacturer.
2. Blue Book Cost, by Manufacturer, shall be determined as follows:
   a. Readymade Capsules, Pills, Tablets, and similar Substance—Cost per 100 units.
   b. Readymade Liquids—Cost of 16 ozs.
   c. Readymade Ointments and Powders dispensed from Bulk Package—Cost per pound.
   d. Originals—Ear Drops, Eye Drops, Nose Drops, Sprays, and Ointments in tube or jar —Cost of Package.
   e. Injectables—Cost of Ampules—Cost of Vials.
   f. Compounded Prescription—Cost of Ingredient plus 50¢.

H. *Dispensing Fee* means the fixed amount established by the Plan which is paid to the Participating Pharmacy over and above the Acquisition Cost for each Prescription Order or refill dispensed.

I. *Prescription Medications* means drugs or biologicals dispensed for human use pursuant to a Prescription Order which are legend drugs, and are thus required, under the Federal Food and Cosmetic Act, to bear the legend: "Caution, Federal law prohibits dispensing without prescription." Excluded are contraceptive medications unless specifically included as an option. At the discretion of Blue Shield, certain devices may be included if related to the use of the prescribed medication.

J. *Participating Pharmacy* shall mean any licensed pharmacy which has entered into an agreement with the Plan to provide the pharmaceutical services listed in the Subscriber's contract.

K. *Participating Contract* shall mean the agreement entered into between the Plan and the Participating Pharmacy which shall set forth their respective rights and obligations.

SECTION II. GENERAL AGREEMENT OF PARTIES

THIS AGREEMENT, made this ..... day of ....., 19...., by and between Kansas Physicians' Service (hereinafter called 'Blue Shield') and ..... (hereinafter called 'Pharmacy'), doing business as a pharmacy with Pharmacy Permit No. ..... located at .... has a current valid permit issued by the Kansas State Board of Pharmacy. The Pharmacy is conducted as a (partnership), (sole proprietorship), (corporation).

Blue Shield agrees that it will furnish to all eligible Subscribers an Identification Card which the Subscriber must present to the pharmacist before he is required to render services. The Pharmacy agrees to provide to such properly identified Subscribers the Prescription Medications required by their Prescription Orders, which are covered under the Subscriber's Prescription Medication Rider or Contract. Prescription Orders must be

made by a duly licensed physician, dentist, or podiatrist in the authorized course of his practice. The pharmacist need not dispense a Prescription Order which for any reason, in his professional judgment, should not be honored. Prescription Medications covered under the Rider or Contract include only those drugs or biologicals dispensed for human use pursuant to a Prescription Order which are legend drugs, and are thus required, under the Federal Food and Cosmetic Act, to bear the legend: "Caution, Federal law prohibits dispensing without prescription." Excluded are contraceptive medications unless specifically included as an option. Refills shall not be covered after one (1) year from the date of the Prescription Order. The quantity of Prescription Drugs dispensed pursuant to an original Prescription Order shall be limited to a supply of thirty-four (34) consecutive days, except that Prescription Orders for medication whose acquisition cost is not greater than $1.00 shall be limited to 100 unit doses for each prescription.

Blue Shield will have the sole right, subject to the above, to determine the individuals eligible for service by the pharmacist for which he is to be reimbursed. The Pharmacy agrees to furnish Blue Shield, on forms to be provided by Blue Shield, a true and correct statement for the Prescription Medications dispensed, including the patient's name and identifying number, the acquisition cost, the total Prescription Charge, and the amount (if any) payable by the Subscriber pursuant to this Contract, and other pertinent information in accordance with the Participating Pharmacy Manual.

Blue Shield agrees to pay as reasonable compensation for the Pharmacy's services an amount equal to the Pharmacy's usual and customary pricing basis but in no instance greater than the Blue Book Cost, and a Dispensing Fee of Two Dollars ($2.00). The Pharmacy agrees to accept in full for its services the payment described in this paragraph without any charge to the Sub-

scriber except for those Subscribers who select the shared payment plan. In this instance, the Pharmacy shall credit the Subscriber in accordance with the plan selected.

The Pharmacy agrees to allow Blue Shield or its duly authorized agent free access to and to furnish such agent during regular business hours, upon demand, such books, records, and prescription files as may be necessary to perform an audit to insure that Acquisition Costs are as reported on claims. It is understood that all information so furnished shall be held as confidential by Blue Shield. Such audits may be made at any time during the term of this Contract or within one year thereafter.

It is understood that the Pharmacy may enter into agreements with any other prepaid prescription drug program and/or commercial insurance company, whether profit or non-profit.

Blue Shield retains the exclusive right to the name 'Blue Shield' and the Blue Shield symbol together with any distinctive trademark and/or service mark that may hereafter be adopted. The Pharmacy agrees not to advertise to the public that it is a Participating Pharmacy nor to use the names, symbols, or trademarks, or 'Blue Shield' in any advertising without the prior written consent of Blue Shield. Upon termination of this Contract, the Pharmacy will immediately discontinue the use of such names, symbols, or trademarks and immediately return any signs, plaques, insignias, displays, or any other advertising material indicating its participating status.

Blue Shield shall not be responsible for any claims arising out of or through the manufacturing, compounding, dispensing, and use of any Prescription Drugs whether covered under this Contract or not, and the Pharmacy agrees to hold Blue Shield harmless against any such claim or demand.

This Contract may be amended at any time by attaching hereto an amendment properly executed by all parties to this Contract.

This Contract may be terminated by either party on thirty (30) days written notice. However, during the said thirty (30) day period, both parties agree that this Contract and its obligations hereunder shall remain in full force and effect.

Blue Shield, notwithstanding the above, reserves the right to cancel this Contract at any time for any breach of this Contract by the Pharmacy and its participation shall terminate forthwith. This right to immediate cancellation by Blue Shield does not in any way effect its other rights enumerated under this Agreement.

No person, agent, or officer of Blue Shield is authorized to alter or vary the terms hereof, nor to make any representation or inducements relative hereto other than those specifically set forth herein. This Contract represents the complete and total agreement of the parties.

Signed and sealed this ..... day of ....., 19.....

..... KANSAS PHYSICIANS' SERVICE

By ..... By .....

(Title) (Title)

(seal) (seal)

APPENDIX E

Department of Justice Clearance, January 15, 1968:

(Letterhead Of)

DEPARTMENT OF JUSTICE

January 15, 1968

Gerald L. Goodell, Esquire
Goodell, Casey, Briman,
Rice & Cogswell
Columbian Building
Topeka, Kansas 66603

Dear Mr. Goodell:

This responds to your letter request of August 30, 1967 for a clearance by the Department of Justice under the Business Review Procedure for a proposed prepaid prescription drug plan to be offered by the Kansas Physicians Service, a non-profit corporation commonly known as Kansas Blue Shield. A copy of a summary of the Department's Business Review Procedure is attached.

Your August 30, 1967 letter outlining the nature of the proposed plan, your supplemental letter of September 27, 1967, and the attached operative documents which are to be used in carrying out the proposed plan have been reviewed.

We understand from your representations that the prices to be paid participating pharmacists, including the amount of the dispensing fee, have been unilaterally determined by Blue Shield, and that future changes in prices will also be determined unilaterally. In this connection, we understand that the prepaid prescription drug plan does not contemplate inviting any concerted action among the pharmacists, or within any pharmaceutical association, pursuant to which pharmacists would agree upon or jointly act in determining whether to join the plan or in determining

the schedule of drug prices or the amount of the dispensing fees to be paid by Blue Shield.

We also understand that the 25% differential in fees paid non-member pharmacists reflects a reasonable assessment of the additional administrative expenses in processing such claims.

This is to advise that on the basis of the information submitted, the Department does not propose to initiate any proceedings under the federal antitrust laws to prevent placing the plan into effect in the manner outlined in your letters. In view of the novelty of the proposal, we reserve the right to assess its actual operation and to take appropriate action in the event experience under the plan or the manner in which the plan is implemented indicates a violation of the antitrust laws.

Sincerely yours,
/s/ Donald F. Turner
Assistant Attorney General
Antitrust Division

Attachment

APPENDIX F

**Department of Justice Clearance,
October, 1968 (Paid Prescriptions)**

October 1, 1968

James Robert Nielsen, Esq.
General Counsel
Paid Prescriptions
Post Office Drawer 5335
Carmel, California 93921

Dear Mr. Nielsen:

This responds to your request of September 18, 1968 under the Business Review Procedure for an expression by the Department of Justice of its enforcement intentions concerning the proposed course of business conduct to be followed by Paid Prescriptions, Inc. We have previously furnished you with a copy of the text of the Business Review Procedure of the Department.

In your letters of September 16 and 18, 1968 you have described the manner in which Paid Prescriptions has been restructured and the changes that are proposed to be made in the terms of the Participating Pharmacy Agreements which establish the drug prices and professional fees to be paid to participating pharmacists.

We understand from your representations that the prices for drugs and professional fees to be paid to pharmacists with which Paid Prescriptions proposes to contract have been unilaterally determined by Paid Prescriptions and that any changes in such drug prices or professional fees will also be determined unilaterally. We further understand that Paid Prescriptions does not contemplate inviting or acquiescing in any concerted action among pharmacists or any pharmaceutical

associations pursuant to which pharmacists will jointly act in determining whether to enter into the proposed contract with Paid Prescriptions or in determining the drug prices or professional fees to be charged for prescriptions furnished to persons who are beneficial members of Paid Prescriptions, Inc.

This is to advise you that on the basis of the information submitted the Department does not propose to initiate any criminal proceedings under the federal antitrust laws if the proposed revisions in the prepaid prescription program are carried out in the manner described in your letters and the accompanying documents.

Sincerely yours,

/s/ EDWIN M. ZIMMERMAN
Assistant Attorney General
Antitrust Division